Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 01 - MAIN BUILDING 01 A. BUILDING B. WING 05/29/2012 TN7601 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 287 BAKER STREET **HUNTSVILLE MANOR** HUNTSVILLE, TN 37756 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Maintenance Director will present a N 002 1200-8-6 No Deficiencies N 002 calendar monthly to the safety committee and add to the monthly agenda. Routinely on weekly basis No Licensure deficiencies cited. that will be ongoing. Monitoring of corrective action to ensure the deficient practice will not recur: 4. NHA will assure compliance by weekly review for 4 weeks to ensure calendar is current and all inspections and drills are incompliance. Overall findings will be reported to the NHA immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. Report of overall findings and subsequent disciplinary action, if applicable, will be reported to the facility Quality Assurance (QA) Committee (consisting of Medical Director, Pharmacy Consultant, Dietician, Psychologist, Central Supply Clerk, Wound Care Nurse, DON, ADON, SSD, NHA, Risk Manager, MDSC, Restorative and/or Nurse., and Housekeeping Supervisor) to review the need for continued intervention or amendment to the plan. 7/15/12 July 15, 2012 Completion date: (X6) DATE Division of Health Care Facilities Jullian 6-15-62 Administrator LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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